

NATIONAL HEALTH PROGRAMS OF INDIA



Centurion
UNIVERSITY

Shaping Lives...
Empowering Communities...

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CONTENT

- INTRODUCTION
- NATIONAL HEALTH MISSION
- REPRODUCTIVE AND CHILD HEALTH PROGRAMS
- REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAM (RNTCP) : DOTS STRATEGY
- NATIONAL AIDS CONTROL PROGRAM
- NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAM
- NUTRITIONAL PROGRAMS
- NATIONAL ANTI-TOBACCO PROGRAM

- NATIONAL ORAL HEALTH PROGRAM
- NATIONAL PROGRAM FOR PREVENTION AND CONTROL OF CANCER, DIABETES, CVD AND STROKE
- INTEGRATED DISEASE SURVEILLANCE PROJECT
- BASIC MINIMUM SERVICE PROGRAM
- PROGRAMS FOR WATER AND SANITATION
- 20-POINT PROGRAM
- CONCLUSION
- REFERENCES



“Those who would benefit most from a service are least likely to obtain it!”



INTRODUCTION

Over the decades the public health is able to deliver best of its capacity to bring changes in various health indicators. (Koppaka R 2011).



Reduction of child mortality



Access to safe water and sanitation



Prevention and control of HIV/AIDS



Malaria prevention and control




Tobacco control



TB control

Various challenges to Public Health



Poverty, Inequity

Public Demands, Marginalizing Public Health Services, Public health delivery

Epidemiological transition

Climatic change and environmental health, New psychosocial issues, Rapid population growth

- Since India became independent, several measures have been taken under by the National Government to Improve the health of the people.
- Program among these measures are the NATIONAL HEALTH PROGRAMS, which have been launched by the central government of control/ eradication of communicable diseases, improvement of environmental sanitation, raising the standard of nutrition, control of population and improving rural health.

- Various International agencies like WHO UNICEF UNFPA world Bank, as also a no. of foreign agencies like SIDA DANIDA NORAD USAID have been providing technical and material assistance in the implementation of these programs.



MINISTRY OF FOREIGN AFFAIRS OF DENMARK
DANIDA INTERNATIONAL
DEVELOPMENT COOPERATION




NORWEGIAN MINISTRY
OF FOREIGN AFFAIRS



NATIONAL HEALTH MISSION

Major Milestones so far are :

1992 – Child Survival And Safe Motherhood Program (CSSM)

1997 – RCH I

1997 – RCH II

2005 – National Rural Health Mission

2013 – RMNCH + A Strategy

2013 – National Health Mission

2014 – India New Born Action Plan (INAP)

- Long standing need of urban health mission was accepted in MAY 2013 by the cabinet of the government of India and rural and urban health mission merged to form National Health Mission in 12th Five year plan.

The vision of mission is :

Attainment of Universal access to equitable, affordable and quality health care services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health.

GOALS

The endeavor of NHM would be to ensure achievement of following indicators:

- 1) Reduce MMR to 100
- 2) Reduce IMR to 25
- 3) Reduce TFR to 2.1
- 4) Prevention and reduction of anemia in women aged 15-19 years to 28%
- 5) Prevention & reduce mortality and morbidity from communicable, non-communicable (including mental illness) ; & injuries.
- 6) Reduce household out of pocket expenditure on total health care expenditure

- 7) Reduce annual incidence and mortality from tuberculosis by half
- 8) Reduce prevalence of leprosy to $<1/10000$ population and incidence to zero in all districts
- 9) Annual malaria incidence to be $<1/1000$
- 10) Less than 1 percent microfilaria prevalence in all districts
- 11) Kala-azar elimination by 2015, <1 case per 10000 population in all blocks.
- 12) Sustaining dengue case fatality rate as $<1\%$
- 13) Containment of outbreak of chikungunya
- 14) Reduce mortality from Japanese Encephalitis by 30%

15) Reduce new infections to zero and provide comprehensive care & support to all persons living with HIV/AIDS and treatment services for all those who require it.



INSTITUTIONAL STRUCTURE OF NHM:

- ✓ Approved by cabinet
 - ✓ National level
-
- ```
graph LR; A[Approved by cabinet] --- B[Mission steering group MSG]; C[National level] --- B; C --- D[Empowered program committee EPC];
```
- ✓ MSG – Union Ministry of Health & Family Welfare – policy direction to the mission.
  - ✓ Convenor – Secretary , Dept of Ministry of Health & Family Welfare
  - ✓ Co-Convenor – Additional Secretary & Mission Director – Mission is headed by him/her – with the team of Joint Secretaries.
  - ✓ Planning, Implementing and Monitoring mission activities.



- ✓ Technical support to the Centre and States – National Health Systems Resource Centre (NHSRC)
- ✓ Country's apex body for training and public health research & support to health and family welfare program – National Institute of Health & Family welfare (NIHFW)
- ✓ Knowledge resources of National Disease control program – National Centre for Communicable Diseases.
- ✓ Additional knowledge resources – AIIMS ,PGIMER & othe institutes of public health in states.

## STATE LEVEL :



**DISTRICT HEALTH MISSION (DHM)/CHM:** Chair person Zila Parishad/Mayor

**District Health Society (DSH):** District Collector

✓ These will coordinate with the other departments and links with research institutes, public health colleges at National and State level.

## APPROACH :

- ✓ Increase access to decentralized health systems by establishing new infrastructure in deficient area.
- ✓ Provide facility based service delivery.
- ✓ District Hospital and Knowledge Centre (DHKC)
- ✓ Outreach services
- ✓ Village Health sanitation and nutrition committee ( VHSNC)
- ✓ Behavior change communication (BCC) Programs
- ✓ Partnership with NGOs , Civil society and for Profit Private sectors
- ✓ Health of Tribal
- ✓ Undertaking two Pilot districts for Universal health coverage
- ✓ Health management Information system (HMIS)

## Service Delivery Strategies :

- Reproductive, Maternal, Newborn , Child Health and Adolescent services ( RMNCH + A)
- ***Control of communicable diseases :***
  - National Vector Borne Diseases Control Program (NVBDPCP)
  - Revised National Tuberculosis control Program (RNTCP)
  - National Leprosy Control Program (NLCP)
  - Integrated Disease surveillance project (IDSP)
- ***Control of NCD :***
  - National Program For Prevention And Control Of Cancer, Diabetes, CVD And Stroke (NPCDCS)
  - National Program For Control Of Blindness (NPCB)

- National Program for Health care of Elderly (NPHCE)
- National Mental Health Program ( NMHP)
- NATIONAL Tobacco Control Program (NTCP)
- National Oral Health Program (NOHP)
- National Program For Palliative Care (NPPC)
- National Program For Preventive And Management Of Burn Injuries (NPPMBI)
- National Program For Prevention And Control Of Fluorosis (NPPCF)

### Financing :

- (i) NRHM/RCH Flexi-pool
- (ii) NUHM Flexi-pool
- (iii) Flexi-pool for Communicable diseases
- (iv) Flexi-pool for NCD including injury and trauma
- (v) Infrastructure maintenance
- (vi) Family Welfare Central Sector Component
- (vii) State : State's Program Implementation Plan (PIP)

On-demand group of skilled and experienced staff that agencies call upon when needed.

- Mission flexipool of NRHM
- **Funds Release Sanction Orders To Districts Under Mission Flexipool**

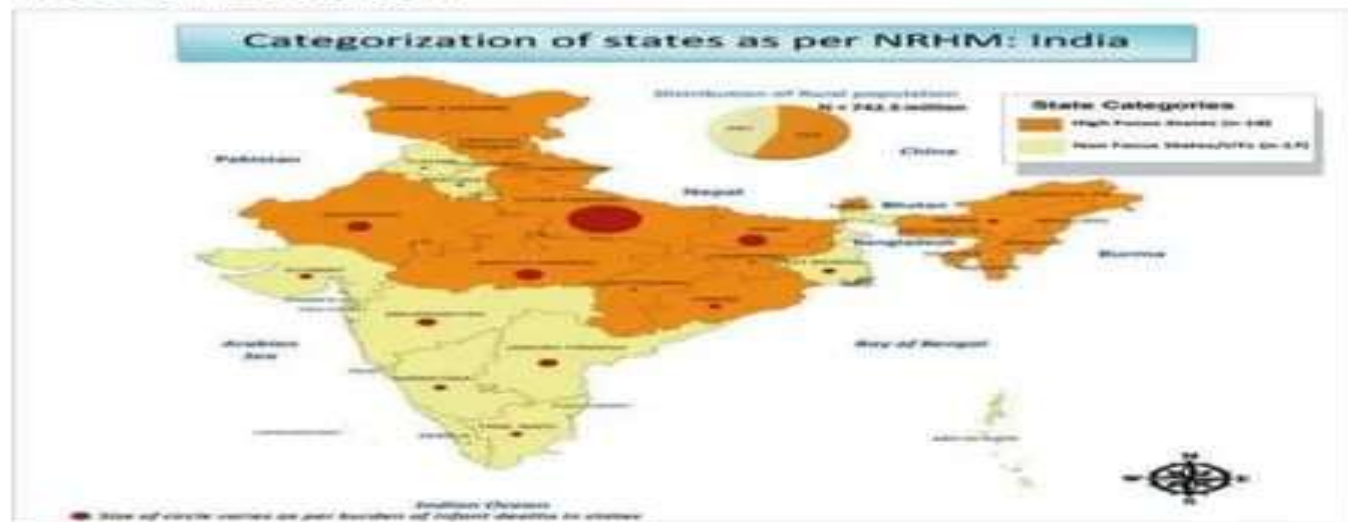
**Recent New Initiatives :**

- ✓ Rashtriya Bal Swasthya Karyakram (RBSK)
- ✓ Rashtriya Kishore Swasthya Karyakram (RKSK)
- ✓ Weekly Iron Folic Acid Supplementation Program (WIFS)

**NATIONAL RURAL HEALTH**  
**MISSION**



- Government of India Launched NHRM – 5<sup>th</sup> April 2005
- Period = 7 years (2005-2012)
- Extended upto 2017
- Improving rural healthcare delivery system
- Focus on 18 states :



- It is also bringing the Indian system of medicine (AYUSH) to the main stream of healthcare.

*AIM :To provide accessible, affordable, accountable, effective and reliable primary health care and bridging gap in rural health care through creation of a cadre of **Accredited Social Health Activist (ASHA)**.*



### Action Points:

- Provision of health activist in each village
- Village health plan prepared through panchayat involvement
- Strengthening of rural hospitals
- Integration of vertical health programs (leprosy, TB, malarial programs, etc.) and traditional medicine
- Integration of plans at different levels
- New health financing mechanisms

### Core Strategies:

- ✓ Train and enhance capacity of Panchayat Raj institutions to own, control and manage public health services.
- ✓ Promote access to improved health care at household level through the female health activist.
- ✓ Health plan for each village through village health committee of the panchayat.
- ✓ Strengthening sub center through an united fund to enable local planning and action and more MPW's.
- ✓ Strengthening existing PHC's and CHC'c.
- ✓ Preparation and implementation of an intersect district health plan prepared by the district health mission .
- ✓ Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.
- ✓ Developing capacities for preventive health care at all levels by promoting healthy life styles, reduction in tobacco consumption, alcohol etc.

### Supplementary strategies

1. Regulation of private sector to ensure availability of quality service to citizens at reasonable cost.
2. Mainstreaming AYUSH – revitalizing local health traditions.
3. Reorienting medical education to support rural health issues including regulation of Medical care and Medical Ethics.
4. Effective and viable risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

### Plan of action/Components:

- Accredited social health activists (ASHA)
- Strengthening sub-centers
- Strengthening primary health centers
- Strengthening CHCs for first referral
- District health plan under NRHM
- Strengthening disease control program
- Public-private partnership for public health goals, including regulation of private sector
- New health financing mechanisms
- Reorienting health/medical education to support rural health issues

## ASHA

- Resident of the village, a woman (M/W/D) between 25-45 years, with formal education up to 8<sup>th</sup> class, having communication skills and leadership qualities.
- One ASHA per 1000 population.
- Around one 100,000 ASHA's are already selected.
- Chosen by the panchayat to act as the interface between the community and the public health system.
- Bridge between the ANM and the village.
- Honorary volunteer, receiving performance based compensation .

- **Responsibility of ASHA:**

- To create awareness among the community regarding nutrition, basic sanitation, hygienic practices, healthy living.
- Counsel women on birth preparedness, imp of safe delivery, breast feeding, complementary feeding, immunization, contraception, STDs
- Encourage the community to get involved in health related services.
- Escort/ accompany pregnant women, children requiring treatment and admissions to the nearest PHC's.
- Primary medical care for minor ailment such as diarrhea, fevers
- Provider of DOTS.
- Act as a depot holder for essential provisions



- Role as a provider – trained for new born care and management
- Information about birth and deaths in the village, outbreak of any disease in community to sub-centre and PHCs
- Promote construction of house-hold toilets.

***ROLE AND INTEGRATION WITH ANGANWADI :***

- Organizing health day once/twice a month
- AWW and ANM train ASHA
- IEC activities : display of posters and dances etc
- Depot holder for drug kits : issue to ASHA
- Update the list of children less than one year of age with the help of ASHA
- ASHA support mobilizing lactating and pregnant women for nutritional care.

- ***Role and Integration with ANM:***

- ANM and ASHA weekly/ fortnight activity meetings
- Train ASHA
- Provide ASHA date and time for out reach programs
- Provide data to ASHA updating the list of children and eligible couples
- Help in organizing health days with AWW
- Utilize ASHA for motivating pregnant women for regular check ups
- Orient ASHA on the dose schedule and side effects of oral pills
- ANM will educate ASHA for danger signs of pregnancy and labour
- Provide ASHA date time and place for training schedules.

***Other Initiatives of NRHM:***

- ✓ Rogi Kalyan Samiti (Patient welfare committee / Hospital Management society)
- ✓ The united grants to sub-centres
- ✓ The Village Health Sanitation and Nutrition Committee
- ✓ Janani Suraksha Yojana
- ✓ Janani Shishu Suraksha Karyakram (1<sup>st</sup> of June 2011)
- ✓ National Mobile Medical Units
- ✓ National Ambulance Services
- ✓ Web Enabled mother and child tracking systems

### *Few New Initiatives :*

- ✓ Home delivery of contraceptives by ASHA
- ✓ Conducting District Level Household Survey
- ✓ Involving ASHA in home based new born care
- ✓ Free drug and diagnostic services
- ✓ WIFS
- ✓ RBSK feb 2013
- ✓ RKSK jan 2014
- ✓ Mother and child health wings
- ✓ Delivery points
- ✓ Universal health coverage

### **Achievements:**

- ✓ 8.06 lakhs/8.89 lakh ASHAs have been trained and provided with the kits
- ✓ 1.47 lakh sub-centres in the country are provided with united funds of Rs.10,000 each.
- ✓ 31,109 Rogi Kalyan Samitis have been registered
- ✓ 8,129 doctors, 70,608 ANMs, 34,605 staff nurses, 13,725 paramedics have been appointed on contract.
- ✓ 2,127 MMU are operational
- ✓ Emergency transport systems are operational in 12 states
- ✓ India declared polio free country, neonatal tetanus declared eliminated in 7 states , JE vaccination is completed in 11 districts and 4 states.
- ✓ JSY in all states, 106.57 lakh got benefitted
- ✓ Integrated management of neonatal and childhood illness (IMNCI) started in 310 districts.
- ✓ Monthly health and nutritional days been organized in various states
- ✓ 5.12 lakh village health sanitation and nutrition committee.
- ✓ School health programs in 26 states initiated.

**NATIONAL URBAN HEALTH**  
**MISSION**

*NUHM will focus:*

- 1) Urban poor population living in listed and unlisted slums.
  - 2) All other vulnerable population
  - 3) Public Health thrust on sanitation, clean drinking water , vector control etc.
  - 4) Strengthening public health capacity of urban local bodies.
- ✓ Seven metropolitan cities – Municipal corporation – NUHM
  - ✓ Urban Health Delivery System : U-PHC, U-CHC
  - ✓ Out reach services : Female Health workers, ANM
  - ✓ Effective participation of community in planning and management through ASHA or link workers and through creation of community based institutions like MAHILA AROGYA SAMITI (MAS)

# REPRODUCTIVE AND CHILD HEALTH PROGRAMS





- **Definition**

“People Have Ability To Reproduce And Regulate Their Fertility , Women Are Able To Go Through Pregnancy And Their Birth Safely, the Outcome Of Pregnancy Is Successful In Terms Of Maternal And Infant Survival And Well Being And Couples Are Able To Have Sexual Relations Free Of Fear Of Pregnancy And Of Contracting Disease”.

- **RCH PHASE 1 PROGRAMME INCORPORATED THE 4 COMPONENT**

|                                      |                                                      |
|--------------------------------------|------------------------------------------------------|
| <b>FAMILY PLANNING</b>               | <b>CHILD SURVIVAL AND SAFE MOTHER HOOD COMPONENT</b> |
| <b>CLINET APPROCH TO HEALTH CARE</b> | <b>PREVENTION \ MANAGEMENT OF RTI\STD AIDS</b>       |

### Main Highlights Of RCH Program Are

- ✓ The Program Integrates All Interventions Of Fertility Regulation, Maternal ,Child Reproductive Health For Both Men And Women.
- ✓ The Services To Be Provided Are Client Oriented
- ✓ The Program Envisages Upgradation Of The Level Of Facilities For Providing Various Interventions And Quality Of Care. The First Referral Units Being Set Up At Sub-district Level Provide Comprehensive Emergency Obstetric And New Born Care.

4. The facilities of obstetric care, **MTP** and **IUD** insertion in the **PHCs** level are improved. **IUD** insertion facilities are also available at sub-centres.
5. Specialist facilities for **STD** And **RTI** are available in all district hospitals and in a fair number of sub-district level hospitals.
6. The program aims at improving the out reach of services primarily for the vulnerable population.

### *RCH services and major interventions*

1. Essential obstetric care
2. Emergency obstetrical care
3. 24 -hour delivery services at PHCS\CHCS
4. Medical termination of pregnancy MTP act 1971
5. Control of reproductive tract infections and sexually transmitted diseases
6. Immunization
7. Drug and equipment kits : equipment kits supplied at various levels as follows:


- At sub-centre level : United Nations Office for Project Services

Drug kit A

Drug kit B

Mid- wifery kit

Sub- centre equipment kit

- At PHC level- PHC equipment kit 
- At CHC level- equipment kits from kit E to kit P

8. Essential newborn care

9. Oral rehydration therapy 1986-87

10. Prevention and control of vitamin A deficiency in children

1. Normal Delivery Kit.
2. Equipment for assisted vacuum delivery.
3. Equipment for assisted forceps delivery.
4. Standard Surgical Set (for minor procedures like episiotomies stitching).
5. Equipment for Manual Vacuum Aspiration.
6. Equipment for New Born Care and Neonatal Resuscitation.
7. IUCD insertion kit.
8. Equipment/reagents for essential laboratory investigations.

**KIT A**

| S. No | Name of the Drug / Form                | Dosage                                                                            | Quantity Per kit           |
|-------|----------------------------------------|-----------------------------------------------------------------------------------|----------------------------|
| 1     | Oral Rehydration Salt (ORS)            | Reduced osmolarity ORS as per WHO                                                 | 150 packets                |
| 2     | Iron & Folic Acid Tablet (IFA) - large | Dried Ferrous Sulphate equivalent to Ferrous Iron 100 mg & Folic Acid 0.5 mg      | 7500 tablets               |
| 3     | Folic Acid Tablet                      | 5 mg                                                                              | 750 tablets                |
| 4     | Iron & Folic Acid Tablet (IFA) - small | Dried Ferrous Sulphate equivalent to Ferrous Iron 20 mg & Folic Acid 0.1 mg       | 6500 tablets               |
| 5     | Cotrimoxazole Tablet (Pediatric)       | Trimethoprim 20 mg / Sulphamethoxazole 100 mg                                     | 500 tablets                |
| 6     | Gentian Violet Crystals                | Crystals                                                                          | 125 gm                     |
| 7     | Zinc Sulphate tablets                  | Dispersible tablet with Elemental Zinc 20 mg                                      | 530 tablets                |
| 8     | Iron & Folic Acid Syrup                | Ferrous Sulphate equivalent to Ferrous Iron 100 mg and Folic Acid 0.5 mg per 5 ml | 200 bottles of 100 ml each |
| 9     | Vitamin A Syrup                        | Each ml contains:<br>100 000 IU Vitamin A                                         | 12 bottles of 100 ml each  |

**KIT B**

| S. No | Name of the Drug / Form              | Dosage                                 | Quantity Per kit                                  |
|-------|--------------------------------------|----------------------------------------|---------------------------------------------------|
| 1     | Methyl Ergometrine Maleate Tablet    | 0.125 mg                               | 120 tablets                                       |
| 2     | Paracetamol Tablets                  | 500 mg                                 | 500 tablets                                       |
| 3     | Methyl Ergometrine Maleate Injection | 0.2 mg/ml, 1ml ampoule                 | 5 ampoules                                        |
| 4     | Albendazole Tablet                   | 400 mg                                 | 100 tablets                                       |
| 5     | Dicyclomine hydrochloride Tablet     | 10 mg                                  | 90 tablets                                        |
| 6     | Chloramphenicol Eye Ointment         | 1% w/w<br>Chloramphenicol in applicaps | 250 applicaps.<br>Each contain 250 mg of ointment |
| 7     | Povidone Iodine Ointment             | 5% w/w                                 | 5 tubes of 15 gm                                  |
| 8     | Cotton Bandage                       | 7 cm X 1 meter                         | 60 Rolls                                          |
| 9     | Absorbent Cotton                     | 100 gm each                            | 5 Rolls                                           |

- Kit-E – Laparotomy set
- Kit-F - Mini– Laparotomy set
- Kit-G – IUD insertion set
- Kit-H – Vasectomy set
- Kit- I – Normal delivery set
- Kit- J – Vacuum extraction set
- Kit- k – Embryotomy set
- Kit- L – Uterine evacuation set
- Kit-M – Equipment for anesthesia
- Kit-N- Neonatal resuscitation set
- Kit-O- Equipment and reagent for blood test
- Kit-P – Donor blood transfusion set



Under the program , doses of vitamin A are given to all children under 5 years of age.

- The first dose( 1 lakh units) is given at nine months of age along with measles vaccination
- The second dose is given along with DPT\ OPV booster doses
- Subsequent doses ( 2 lakh units each) six months intervals

11. Acute respiratory disease control cotrimoxazole is being supplied to the health worker through the CSSM drug kit

12. Prevention and control of anemia in children under this program of control and prevention of anemia ,tablets containing 2mg of elemental iron and 0.1 mg of folic acid are provided at sub-centre level .

The health workers to provide 100 tablets to children clinically found to be anemic.

## REPRODUCTIVE AND CHILD HEALTH PROGRAMME -PHASE II

RCH –PHASE II began from 1st April 2005, the focus is to reduce maternal and child mortality and morbidity with emphasis on rural health care. The major strategies are

- 1) Essential obstetric care
  - a. Institutional delivery
  - b. Skilled attendance at delivery
- 2) Emergency obstetric care
  - a. operationalizing first referral units
  - b. operationalizing **PHCS** and **CHCS** for round clock delivery services

- ✓ There are 3 critical determinants of facility
- Availability of surgical interventions
- Newborn care
- Blood storage facility on a 24 hrs

- **NEW INITIATIVES**

1. Training of MBBS doctors in life saving anesthetic skills for emergency obstetric care.

Govt .of India is also introducing training of MBBS doctors of obstetric management skills, prepared training plan for 16 weeks in all obstetric management skills,inculding caesarian section operation.

- 2.Setting up of blood storage centres at FRUs according to government of India guidelines

**JANANI SURAKSHA YOJANA** the national maternity benefit scheme has been modified into a (JSY) JANANI SURAKSHA YOJANA.

- It was launched on 12th April 2005.
- It is a 100% centrally sponsored scheme
- Under national rural health mission ,it integrates the cash assistance with institutional care during antenatal, delivery and immediate post-partum care

| CATEGORY | RURAL AREA       |                 |          | URBAN AREA       |                |          |
|----------|------------------|-----------------|----------|------------------|----------------|----------|
|          | MOTHER'S PACKAGE | ASHA 'S PACKAGE | TOTAL Rs | MOTHER'S PACKAGE | ASHA'S PACKAGE | TOTAL Rs |
| LPS      | 1400             | 600             | 2000     | 1000             | 200            | 1200     |
| HPS      | 700              | -               | 700      | 600              | -              | 600      |

- **VANDEMATARUM SCHEME**

- It is a voluntary scheme wherein any obstetric and gynaec specialist, maternity home can volunteer
- Enrolled doctors will display 'vandemataram logo' at their clinics.
- Iron and folic acid tablets, oral pills, TT injections, etc. will be provided for free distribution.

## **Strategy for addressing Adolescent Reproductive and Sexual Health (ARSH)**

A two-pronged strategy will be supported:

- Incorporation of adolescent issues in all the RCH training programs and all RCH materials developed for communication and behaviour change.
- Dedicated days and dedicated timings for adolescents at PHC's.

## Infection Management And Environment Plan

- ✓ IMEP which is being extended to health care facilities includes:
  - a) Treatment and disposal of biomedical wastes
  - b) Disposal of syringe waste
  - c) Provision of water sanitation and good hygiene conditions



- **SAFE ABORTION PRACTICES**

- Medical Method

- Termination of early pregnancy (49days) using 2 drugs
- mifeprestone followed by mesoprostol

- Manual Vacuum Aspiration

- Safe and simple technique for termination of pregnancy.
- Can be used at PHC or comparable facility
- WHO & state govt. are coordinating the project

## Some Innovative State Initiatives

### Gujarat

- Increase access to safe delivery services. It is in partnership with private providers (Chiranjivi Yojana)
- A Dai Sangathan has been formed by 10 leading NGOs of the state to facilitate interface between the health system and the community

### Punjab

- Proposed to pay an incentive of Rs. 500/- to BPL belonging to urban areas
- Purchase and supply of nutrients like iron, calcium, D-worming tablets for pregnant mothers belonging to SC classes.

- Screening code for Ca Cervix – Tamil Nadu
- Subsidized Medical Practitioner (SMP) scheme- Assam, Bihar
- Nurse Practitioners Scheme
- Laparoscopic Training – Maharashtra
- Implementation of Health Insurance scheme on pilot basis.

**REVISED NATIONAL TUBERCULOSIS**  
**CONTROL PROGRAM (RNTCP) : DOTS**  
**STRATEGY**

## The Beginning :National Tuberculosis Control Program

- Before the Revised National Tuberculosis Program (NTCP) came into force the existing Tuberculosis program had the following objectives:
- To identify and treat as large a number of TB patients as possible so that infectious cases are rendered non- infectious.
- To reduce the magnitude of TB problem in the country to a level where it ceases to be a public health problem.

## Organization and administration

- Central level
- Besides the Tuberculosis Division in the Directorate General Health services, National Tuberculosis Institute, Bangalore and Tuberculosis Research Centre at Chennai
- District level
- A district constitutes a functional unit of the NTCP and is called District Tuberculosis Control Program
- Peripheral level
- Comprises of chest clinics and Primary Health Centers (PHC)

## Program Implementation( prior to RNTCP)

Program activities were:

- Case detection
- Case treatment
- Health education
- BCG vaccination

## Program performance and evolution of RNTCP

- Despite a nationwide network of facilities , NTCP failed to yield satisfactory results. The situation did not change much.
- The case finding efficiency was only 30 of the expected level although the mortality rate decreased to 53/100,00 population
- Government of India launched the Revised National Tuberculosis Control Program(RNTCP) in 1997 encouraged by the results of Pilot studies were tested in 1993-94



## Evolution of TB Control in India

- 1950s-60s      Important TB research at TRC and NTI
- 1962            National TB Program (NTP)
- 1992            Program Review  
  
                      only 30% of patients diagnosed;  
  
                      of these, only 30% treated successfully
- 1993            RNTCP pilot began
- 1998            RNTCP scale-up
- 2001            450 million population covered
- 2004            >80% of country covered
- 2006            Entire country covered by RNTCP

### **Revised National TB Control Program (RNTCP)**

- Launched in 1997 based on WHO DOTS Strategy
- Entire country covered in March'06 through an unprecedented rapid expansion of DOTS
- Implemented as 100% centrally sponsored program
- Govt. of India is committed to continue the support till TB ceases to be a public health problem in the country
- All components of the STOP TB Strategy-2006 are being implemented

## Objectives of RNTCP

- To achieve and maintain a cure rate of at least 85% among newly detected infectious (new sputum smear positive) cases
  
- To achieve and maintain detection of at least 70% of such cases in the population

## Strategy

1. Augmentation of organizational support at the central and state level for meaningful coordination
2. Increase in budgetary outlay
3. Use of Sputum microscopy as a primary method of diagnosis among self reporting patients
4. Standardized treatment regimens.

- 7 Augmentation of the peripheral level supervision through the creation of a sub district supervisory unit
8. Ensuring a regular uninterrupted supply of drugs up to the most peripheral level
9. Emphasis on training, IEC, operational research and NGO involvement in the program

## Core elements of Phase I

- The core element of RNTCP in Phase I (1997-2006) was to ensure high quality DOTS expansion in the country, addressing the five primary components of the DOTS strategy
- Political and administrative commitment
- Good Quality Diagnosis through sputum Microscopy
- Directly observed treatment
- Systematic Monitoring and Accountability
- Addressing stop TB strategy under RNTCP

## **RNTCP Phase II( 2006-11)**

The RNTCP phase II is envisaged to:

- Consolidate the achievements of phase I
- Maintain its progressive trend and effect further improvement in its functioning
- Achieve TB related MDG goals while retaining DOTS as its core strategy

## Public Private Mix (PPM) Activities for Involvement of All Health Care Providers

- Involvement of NGOs and Private Practitioners
- Schemes revised in 2008
- Presently > 2500 NGOs, 17,000 PPs involved
- Involvement of professional bodies like IMA, IAP
- Other Central government departments/PSUs
  - CGHS, Railways, ESI, Mining, Shipping
  - Corporate sector
    - ~150 Corporate Houses participating
- Involvement of FBOs like CBCI
- Involvement of Medical Colleges
  - Task Forces and Core Committees formed
  - 260 Medical colleges involved



**TBC India**  
Directorate General of Health Services  
Ministry of Health and Family Welfare

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## IEC Resource Centre

Initiative supported by DANB, Dandri

About the IEC Resource Centre

The IEC Resource Centre houses specifications and digital formats of representative TB-IEC material. It is a useful tool in information sharing that is crucial to strengthen IEC activities in TB control in India. Users (STOs, NGOs, RNTCP program staff, researchers, community-based organizations, and others) can enroll themselves in the Resource Centre and have access to the material specifications and format which they can modify and adapt to local conditions. A search facility has been provided to select material using a set of criteria. A user's manual is available at the web site to guide users.

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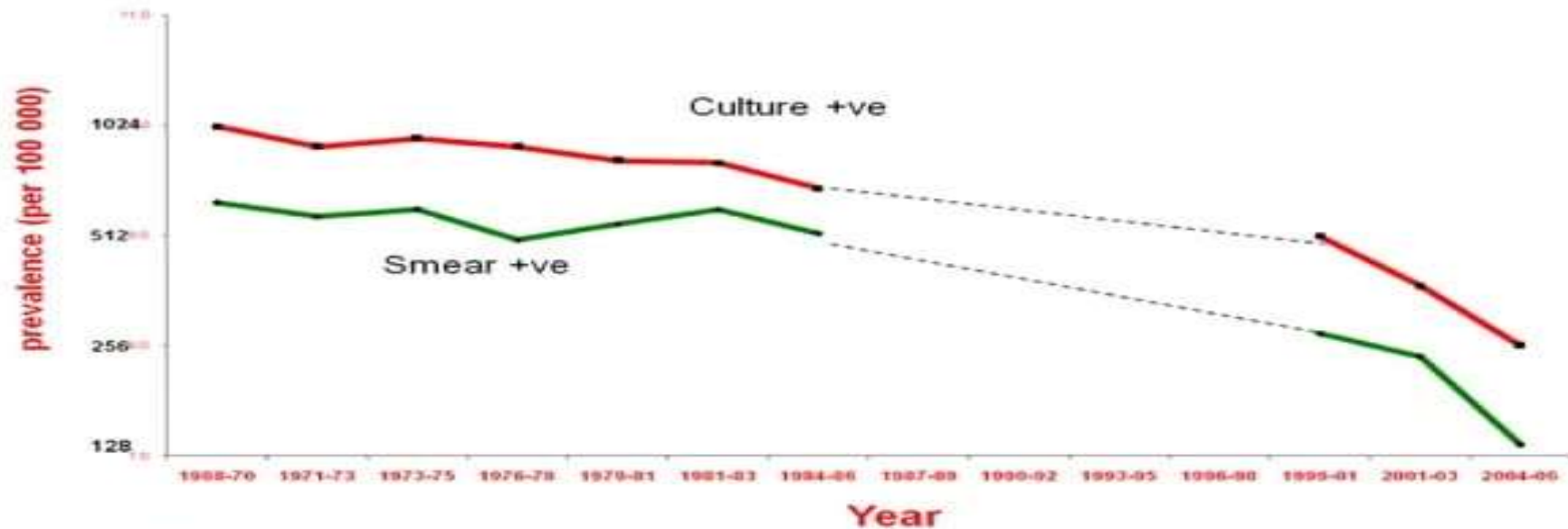
**A Health Communication Strategy for RNTCP**

Directorate General of Health Services  
Ministry of Health and Family Welfare  
Government of India

- Web based resource centre
- Communication facilitators provided to support IEC at district level
- Ongoing capacity building of program managers for planning and implementing need based IEC activities
- WELL DEFINED IEC STRATEGY

## Impact of RNTCP

Trends in prevalence of culture-positive and smear-positive tuberculosis in south India(5 Blocks), 1968-2006



\*Source: WHO Report 2008, Global Tuberculosis Control; pg 71

## **TB-HIV: Accomplishments**

- 2007 – The first national frame work for TB-HIV joint collaborative activities was developed.
- Developed and implemented mechanism for TB & HIV program collaboration at all levels (National, State, District)
- Conducted surveillance and determined national burden of HIV in TB patients
- Mainstreamed TB-HIV activities as core responsibility of both programs (training & monitoring)

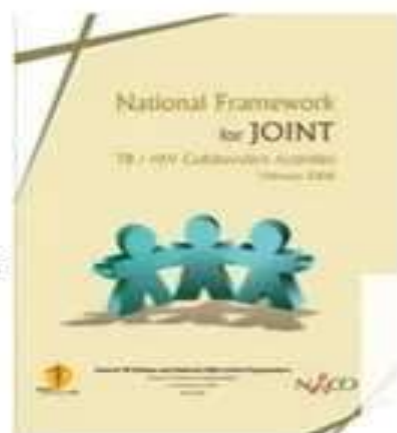
## **TB-HIV: Current Policies (2008)**

TB/HIV activities in all States

- Coordination & Training on TB/HIV
- Intensified Case Finding (ICF)
- Referral of all HIV- TB patients for HIV care and support (CPT & ART)
- Involve NGOs

### **Activities in high-HIV states**

- Provider-initiated HIV counseling and testing for all TB patients
- Decentralized provision of Co-trimoxazole
- Expanded TB-HIV monitoring



## RNTCP- DOTS-Plus Vision

- By 2010 DOTS-Plus services available in all states
- By 2012, universal access under RNTCP to laboratory based quality assured MDR-TB diagnosis for all retreatment TB cases and new cases who have failed treatment
- By 2012, free and quality assured treatment to all MDR-TB cases diagnosed under RNTCP (~30,000 annually)
- By 2015, universal access to MDR diagnosis and treatment for all smear positive TB cases under RNTCP

## **TB in pregnancy :**

- National strategic plan (2012-2017) [12th Five year plan]

Vision : TB Free India

Following thrust areas identified:

- 1) Strengthening and improving the quality of basic DOTS services
- 2) Further strengthen and align with health system under NRHM
- 3) Deploying improved rapid diagnosis at the field level
- 4) Expand efforts to engage all care providers
- 5) Strengthen urban TB control
- 6) Expand diagnosis and treatment of drug resistant TB
- 7) Improve communication and outreach
- 8) Promote research for development and implementation of improved tools and strategies

## Financial Resources:

- 1) World Bank
- 2) Department of International development via WHO
- 3) Supported by Global TB drug facility
- 4) Global fund to fight AIDS, Tuberculosis and malaria
- 5) USAID and DANIDA
- 6) Govt of India 100% grant-in-aid to the implementing agencies besides free drug

**NATIONAL AIDS CONTROL**  
**PROGRAM**



- NACP was launched in India = 1987
- Ministry of Health and Family Welfare has set up NAC organization as a separate wing
- **AIM:**
  - Prevent transmission
  - Decrease morbidity and mortality
  - Minimize socio-economic impact

**Milestones:**

1986 – first case detected – AIDS task force set up by the ICM, National AIDS Committee established

1990 – Medium term plan launched for 4 states and metros

1992 – NACP-I launched

1999 – NACP-II launched

2002 – National AIDS Control policy and National Blood Policy adopted

2004- ART initiated

2006 – National council of AIDS constituted under chairmanship of the Prime Minister, National Policy of Paediatric ART formulated

2007 – NACP III launched for 5 years (2007-2012)

2014 – NACP IV launched for 5 years (2012-2017)

**National Strategy : Following components :**

- Establishment of surveillance centres to cover the whole country : HIV sentinel surveillance, HIV Sero- surveillance, AIDS Case surveillance, STD surveillance, Behavioral surveillance, Integration with surveillance of other diseases.
- Identification of high risk group and their screening
- Issue specific guidelines for the management of detected cases and their follow up
- Formulating guidelines for blood bank, blood product manufacturers, blood donors and dialysis units
- IEC activities by involving mass media and research for reduction of personal social impact of disease
- Control of STDs
- Condom programs

Primary goal of NACP-IV is to halt and reverse the epidemic in India over the next 5 years by integrating programs of prevention, care, support and treatment.

## PPTCT Program

- The Prevention of Parent to Child Transmission of HIV/AIDS (PPTCT) programme was started in the country in the year 2002 following a feasibility study in 11 major hospitals in the five high HIV prevalence states.
- Currently, there are more than 4000 Integrated Counselling and Testing Centres (ICTCs) in the country, most of these in government hospitals, which offer PPTCT services to pregnant women.
- Of these ICTCs, 502 are located in Obstetrics and Gynaecology Departments and in Maternity Homes where the client load is predominantly comprised of pregnant women

**NATIONAL VECTOR BORNE DISEASE**  
**CONTROL PROGRAM**

# MALARIA

- National Malaria control program – 1953 -75 million deaths due to malaria
- 1958 – NMCP was changed into National Malaria Eradication program
- 1965 – Cases reduced to 0.1 million
- Early 1970s resurgence of malaria by 6.46 million cases
- 1977 – Modified plan of operations implemented
- 1997 – World Bank assisted Enhanced malaria control project (EMCP)
- 1999 – Renaming of project to National Anti-malarial program (NAMP)
- 2002 - Renaming NAMP to NVBDCP
- 2005 – Global fund assisted Intensified Malaria control project (IMCP),RDT included
- 2006 – ACT introduced
- 2008 – ACT extended and World Bank supported National Malaria Control project launched
- 2009 – Introduction of LLINs
- 2010 - new drug policy
- 2012 – Introduction of bivalent RDT
- 2013 – New drug policy 2013

**Main activities:**

- 1) Formulating policies and guidelines
- 2) Technical guidance
- 3) Planning
- 4) Logistics
- 5) Monitoring and evaluation
- 6) Coordination of activities through state/UTs and in consultation with National Centre for disease control (NCDC), National Institute of Malarial Research (NIMR)
- 7) Collaboration with international organizations like the WHO, World Bank, GFATM and other donor agencies
- 8) Training
- 9) Facilitating research through NCDC, NIMR, Regional medical research centers
- 10) Coordinating control activities in the inter-state and inter country border areas.

### *Strategic action Plan for malaria control in India (2012-2017)*

- **Vision** : substantial and sustained reduction in the burden of malaria in the near and mid-term, and elimination of malaria in the long term, when new tools in combination with strengthening of health systems will make national elimination possible.
- Malaria control is incorporated under the umbrella of NRHM.
- **Objective** : To achieve Annual Parasite Index < 1per 1000 population by the end of 2017

**Goals:**

- 1) Screening all fever cases suspected to malaria (60% through quality microscopy and 40% by rapid diagnostic test
- 2) Testing all *P.falciparum* cases with full course of effective ACT and primaquine and all *P.vivia* cases with 3 days chloroquine and 14 days primaquine.
- 3) Equipping all health institutions especially in high risk areas
- 4) Strengthening all district and sub-district hospitals.

**Outcome indicators :**

- 1) At least 80% suffering from malaria get correct,affordable,appropriate and complete treatment within 24 hours of reporting
- 2) At least 80% of those at high risk of malaria get protected
- 3) At least 10% of population in high risk areas is surveyed annually



- The major externally supported projects :
  - (I) **Global Fund Supports Intensified Malaria Control Project (IMCP II) :** Implemented since October 2010 for five years involving 7 North East States.
  - (II) **The World Bank Supported Project On Malaria Control And Kala-azar Elimination:** March 2009-December 2013. Financial layout was Rs.1000 crores. Involved 93 malarial districts of 8 States and 46 Kala-azar districts in 3 States. Phase I and II. Phase I = 50 most malarial districts and 46 kala-azar, Phase II = rest of the malarial districts.

## ELIMINATION OF LYMPHATIC FILARIASIS

- 600 million people are exposed.
- National Filarial Control Program since 1955
- 1978 – Merged with Urban Malarial scheme
- Director of National Institute of Communicable disease, Delhi – Training and research components continue to be with him/her.
- Training in filariology is being given at three Regional Filarial Training Research Centres situated in (i) Kerala (ii) Rajahmundry (AP) (iii) Varanasi Under National Institute of Communicable disease, Delhi.
- 12 head quarters bureau are functioning at state level.

- National Health Policy 2002 = elimination of lymphatic filariasis by 2015.
- Elimination defined as “lymphatic filariasis ceases to be the public health problem, when the no. of microfilaria carriers is less than 1% and the children born after initiation of ELF are free from circulating antigenaemia.
- **Strategy** :
  - 1) Annual Mass Drug Administration of single dose of anti-filarial drug for 5 years or more to the eligible population ( except pregnant women, children below 2 years of age and seriously ill-person) to interrupt transmission of the disease.
  - 2) Home based management of lymphedema cases and up-scaling of hydrocele operations in identified CHCs/district hospitals/medical colleges.

## KALA-AZAR

- A centrally sponsored program was launched in 1990-91.
- This has brought down the incidence from 77,102 cases in 1992 to 13,869 cases in 2013.
- **Strategy** :
  - 1) Enhanced case detection and complete treatment including introduction of PK39 rapid diagnostic kits and oral drug Miltefosine.
  - 2) Interruption of transmission through vector control. Decided to replace DDT with synthetic pyrethroid for the purpose of fogging to eliminate sandfly.
  - 3) Communication for behavioral impact and inter-sectoral convergence.
  - 4) Capacity building
  - 5) Monitoring, supervision and evaluation
  - 6) Research guidelines on prevention control of Kala-azar have been developed and circulated to the states.

- Kala-azar fortnight survey
- Rs.300/- for each case identification to ASHA workers
- Rs.100/- for ensuring community support during insecticide spraying
- Rs.500/- as compensation to the patient on daily wages
- Revised strategy of eradication of Kala-azar was launched on 2<sup>nd</sup> December 2014.
- New Strategy :
  - Introduction Of RDT developed by ICMR
  - Single dose treatment with Liposomal Amphoterecin B, IV 10mg
  - WHO supply drug free of cost.

# JAPANESE ENCEPHALITIS

- Japanese encephalitis is a vector borne disease.
- Several species of mosquitoes are capable of transmitting JE virus.
- JE is a zoonotic infection.
- **Control Strategy:**
  1. Care of the patient to prevent sequaele
  2. Development of a safe & Standard vaccine
  3. Sentinel surveillance including clinical surveillance of suspected cases.
  4. Studies to identify high risk cases
  5. Epidemiological monitoring of the disease and effective implementation of preventive and control measures

## Dengue/DHF

- There was a major out break of Dengue /DHF in Delhi in 1996
- Since than many focal outbreaks have been reported from different areas of the country mainly from urban areas.
- This disease has been included in NVBDCP in 2003 -04.

- **Control Strategy:**

- Public awareness and community involvement is the key issue in the strategy to control Dengue/DHF
- All efforts should be made against the breeding of *Aedes aegypti* mosquitoes by source reduction
- Protection from mosquito bites
- Early diagnosis and prompt treatment of cases.
- **Mid term plan of Dengue** developed in 2011. Main components : Surveillance, Case and Vector management, Out break response, Capacity building, Behaviourial change communication , Inter sectoral coordination and monitoring supervision.



## CHIKUNGUNYA FEVER

- Viral fever reemerging after a gap of 3 decades.
- Govt of India continuously monitoring the situation.
- Guidelines for prevention control have been prepared.
- Strategy of Dengue and Chikungunya is same.
- Support in the form of logistics and fund is provided.
- Diagnostic kits are provided by National Institute of Virology, Pune by the central government.

# NUTRITIONAL PROGRAMS

**Ministry of Rural Development**

Applied nutrition program

**Ministry of Social Welfare**

Integrated child development services scheme

Balwadi nutrition program

Special nutrition program

**Ministry of Health and Family Welfare**

National nutritional anemia prophylaxis program

National prophylaxis program for prevention of blindness due to vitamin A deficiency

National iodine deficiency disorder control program

**Ministry of Education**

Mid-day meal program

## APPLIED NUTRITION PROGRAM

- One of the earliest nutritional program.
- This project was started in Orissa on 1963
- Later extended to Tamilnadu and UP

### **Objectives:**

Promoting production and of protective food such Vegetables and fruits

Ensure their consumption by pregnant & lactating women and children.

1973 its extended to all states in INDIA

### **Services**

Nutritional education

Nutrition worth 25 paise for children and 50 paise for pregnant and lactating women for 52 days in a year

The program maintained by Ministry of Rural Development.

## BALWADI NUTRITION PROGRAM

This was started in 1970 under the department of social welfare through voluntary organizations.

Voluntary organizations receiving the grants are responsible for the running of this program

### **Beneficiary group**

Preschool children 3-5years of age.

### ***Services***

300kcal and 10gm protein for 270 days in a year.

Also provide with pre school education

Balawadis are being phased out because universalization of ICDS

## SPECIAL NUTRITION PROGRAM

- Started in 1970 by Ministry of Social Welfare.
- Operation in urban slums, tribal areas and backward rural areas.
- Operated under minimum need program
- Main aim is to improve nutritional status in targeted group.

### **Beneficiary group**

Children below 6 years  
Pregnant and lactating women

### **Services**

Preschool children : 300kcal and 10-12gm protein  
Pregnant & lactating mothers :500kcal and 25 gm protein  
Total of 300 days in a year

Fund for nutrition component of ICDS program was shared with SNP budget

This program is gradually being merged into ICDS

## **INTEGRATED CHILD DEVELOPMENT SERVICE(ICDS) SCHEME**

- Initiated-Oct.2,1975, in 33 CD Blocks under 5th Five Year Plan
- Under Ministry of social welfare
- In succession to objectives of National Children's Policy (Aug. 1974)
- World's largest program for early childhood development
- Centrally sponsored scheme implemented by state/UT Govts.

### **Rationale**

- Routine MCH services not reaching target Population
- Nutritional component not covered by Health services
- Need for community participation

## **Objectives**

- Lay the foundation for proper psychological, physical and social development of child
- Improve nutritional & health status of children
- Reduce incidence of mortality, morbidity, malnutrition and school drop-outs
- Enhance the capability of mother & family
- Achieve effective coordination among various departments

## **Beneficiaries**

- Children < 6 years
- Pregnant & Lactating women
- Women in Reproductive age group (15-44 yr)
- Adolescent Girls (in selected Blocks)



### **Services**

- Supplementary nutrition
- Non-formal pre-school education
- Immunization
- Health Check-up
- Referral services
- Nutrition and Health Education

### **Administration of the scheme**

- Community development block-Rural areas
- Tribal blocks-tribal areas
- Wards/ slums –urban areas

## SUPPLEMENTARY NUTRITION

- Supplementary feeding and Growth monitoring.
- Prophylaxis against Vit. A deficiency.
- Control of Nutritional Anemia.

### **ACTIVITIES**

- Target group identified from community.
- They are provided supplementary feeding support for 300 days in a year.
- Weight for age growth cards are maintained for all children < 6 years.
- Severely malnourished children are given special supplementary feeding and referred to medical services.

## WHEAT-BASED NUTRITION PROGRAM

- Centrally sponsored program, launched in 1986.
- Implemented by the Ministry of Women & Child Development
- Program follows the norms of SNP.
- Providing nutritious/ energy food to children below 6 years of age and expectant /lactating women from disadvantaged sections
- Implemented through ICDS
- Food grains supplied under the program- used to prepare food for supplementary nutrition in ICDS

## NUTRITION PROGRAMME FOR ADOLESCENT GIRLS

➤ Introduced in the year 2002-2003 with 100% Central Assistance

### **Aims**

1. Improve Nutritional and health status adolescent girls.
2. Provide nutrition and health education to the beneficiaries.
3. Empower adolescent girls through increased awareness to take better care of their personal health and nutrition needs.

### **Beneficiaries**

- Adolescent girls <35 Kg
- Pregnant women <45 kg

### **Services**

- 6 Kg ration per month for three months consecutively.
- Implemented through the A.W. Centres
- Weighing four times in a year
- on the basis of the body weight, issuance of live rice will continue for 3 months.
- In Assam, Kokrajhar and Karbi-Anglong as pilot districts.

# NATIONAL NUTRITIONAL ANEMIA PROPHYLAXIS PROGRAM

- Program was launched during 4th 5-year plan in 1970 by the Ministry of Health and Family Welfare
- Prevention of nutritional anemia in mothers and children

## • Rationale

- Supplementary iron on daily basis is considered necessary in developing countries because approaches like food fortification and dietary modification are long term options.
  - Requirements during 2nd and 3rd trimester can't be made by daily intake.
  - Majority of girls are anemic , even in their adolescence.
- Source: Gopalan C. child care in india: emerging challenger bull.1993
- Deleterious effect on neural tube development in folic acid development during 1st 4 weeks of pregnancy

Source: Rosenberg IH. Folic acid and neural tube defect . Time for action?  
New Eng J.Med; 1992

## **Beneficiaries**

- Children 1-5 years of age
- Expecting and lactating mothers
- Family planning (IUD) acceptors

## **Policy**

- Expecting and lactating mothers as well as IUD acceptors -60 mg of elemental iron + 0.5 mg folate everyday for 100 days.
- Children 1-5 years- 20mg of elemental iron + 0.1 mg folate everyday for 100 days.

## WEEKLY IRON AND FOLIC ACID SUPPLEMENTATION PROGRAM FOR ADOLESCENTS

- Also known as WIFS-Blue campaign.
- Nodal agency- Ministry of H&FW

### **Beneficiaries-**

- Adolescent girls/boys enrolled in school, 6th- 12th std.
- Adolescent girls not enrolled in schools



## Services

- IFA tablet to target population on weekly basis on a fixed day(Monday) for 52 weeks.
- Biannual deworming (February and August)



## NATIONAL PROPHYLAXIS PROGRAMME AGAINST NUTRITIONAL BLINDNESS DUE TO VITAMIN A DEFICIENCY

- Launched in 1970 as a centrally sponsored scheme by Ministry of H&FW, Govt.
- Component of National program for control of blindness 1976

### ➤ Rationale

Human liver can store vitamin A when consumed in excess of daily requirements. The stored Vitamin A is released when in need

- Target group- all children 1-3 years of age.
- Activity –Megadose of vit.A (2 lac IU) orally every six months.

## NATIONAL IODINE DEFICIENCY DISORDER CONTROL PROGRAM

- The beginning-Kangra valley study (1956-72)
- National Goitre Control Program launched in 1962, at the end of 2nd 5-year plan by Ministry of H&FW ,Govt.
- Focuses on use of Iodised Salt – Replace of common salt with iodised salt, Cheapest method to control IDD.
- Use of Iodized oil Injection to those suffering from IDD, Oral administration as prophylaxis in IDD severe areas
- Rationale

- No State or UT in India is free from IDD, as evident from the surveys carried by ICMR
- Iodine deficiency leads to a spectrum of disorders mostly affecting physical and mental development
- The fact that human brain development is completed by 3 years of age , iodine deficiency in early age leads to permanent and irreversible damage.
- Fortification of salt is a preventive program, can be considered as a 'vaccine'

The turning point- meeting of prime minister in 1983.

- 1983- Universal iodization of salt (30 ppm at manufacture level and 15ppm at consumption level)
- 1992- program renamed as 'National iodine deficiency disorder control'

### ***Objectives***

- Surveys to assess the magnitude of IDD.
- Supply of iodised salt
- Resurveys 5yearly to assess impact of iodised salt & IDD
- Lab monitoring of iodised salt and UIE
- Health education.

### ***Strategy***

- Iodise entire edible salt in the country by 1992.
- Ban of non-iodised salt under PFA act (1954).

## MID-DAY MEAL PROGRAM

- First started in Tamilnadu.
- Also known as School lunch program.
- Program in operation since 1961 under Ministry of Education.

### **Aim**

- To provide at least one nourishing meal to school going children per day.

### **Objectives**

- Improve the school attendance
- Reduce school drop outs
- Beneficial impact on child's nutrition

### **Principles**

- Supplement and not a substitute to home diet.
- Supply at least 1/3 of the energy requirement and 1/2 of the protein needed
- The cost of meal should be reasonably low.
- Meal prepared easily in schools, no complicating cooking procedures
- Locally available foods should be used
- The menu should be frequently changed

## AKSHAYA PATRA

- Started in 2000, feeding 1500 children in 5 schools in Bangalore.
- Successfully involved private sector participation in the program.
- Program managed with a centralized kitchen that runs through a public/private partnership.
- Food delivered to schools in sealed and heat retaining containers just before the lunch break every day

### **Objectives**

- Providing underprivileged children with a healthy, balanced meal .
- Reduce the dropout rate and increases classroom attendance.
- Improve socialization among castes, address malnutrition
- Empower women through employment.

## NUTRITION PROGRAMME FOR ADOLESCENT GIRLS (KISHORI SHAKTI YOJNA)

- Launched by Dept. of Women and Child Development ,Ministry of Human Resource Development in 1991
- Targeted All adolescent girls in the age group of 11-18 years

### **Common Services**

1. Watch over menarche,
2. Immunization,
3. General health check-ups once in every six-months,
4. Training for minor ailments,
5. De-worming,
6. Prophylactic measures against anemia, goiter, vitamin deficiency, etc., and
7. Referral to PHC. District hospital in case of acute need.
8. Girls are also provided supplementary nutrition at Rs. 2.50 per girl, per day

## MISCELLENOUS

### ✓ **Annapurna Scheme**

- Launched in 2000-2001 by Ministry of Rural Development
- Senior citizens of  $\geq 65$  years of age, not getting the pension under the National Old Age Pension Scheme (NOAPS)
- 10 kgs. of food grains/person/month are supplied free of cost.

### ✓ **Maa-moni**

- Under Assam Bikash Yojna.
- Beneficiaries are pregnant mothers
- Rs. 1000 provided for nutrition and ambulance

### ✓ **Antyodaya Anna Yojna**

- Launched in 25th Dec 2000
- Aim- to create hunger-free india in next 5 year and reform PDS
- Target group- poor families who couldn't afford food grains even at BPL rates
- Service- 35 kg/Family/month of wheat @Rs 2/- & rice @Rs 3/-

### ✓ **CM's Vision for Women and Children 2016**

- Yet to roll in....

**NATIONAL TOBACCO CONTROL**  
**PROGRAM**



- Tobacco control legislation “The Cigarettes and other tobacco product act” in 2003 April was passed by the parliament.
- NTCP : Under WHO-framework Govt of India launch it in 11<sup>th</sup> Five year plan.
- Main Components :
  - 1) Public awareness
  - 2) Establishment of tobacco product testing laboratories
  - 3) Mainstream it under NHRM
  - 4) Mainstream research and training on alternative crops and livelihood
  - 5) Dedicated tobacco control cells
  - 6) Training of health and social workers
  - 7) School programs
  - 8) Provision for tobacco cessation facilities.

# NATIONAL ORAL HEALTH PROGRAM

- A comprehensive oral health care project on a pilot basis was launched by the Directorate General of Health Services, Govt. of India in July 1999 for 3 years in one district each of five states namely Himachal Pradesh, Haryana, Punjab, Delhi and Rajasthan.
- AllMS is the nodal agency for the development of this project.
- Reviewed by National Institute for Health and Family welfare in 2004.
- **Components:**
  - 1) Oral Health Education
  - 2) Formulation of basic package on oral health
  - 3) Manpower and infrastructure requirement for primary and secondary prevention of oral diseases.

Private Sector Involvement : Colgate-Palmolive India and IDA.

**NATIONAL PROGRAM FOR PREVENTION  
AND CONTROL OF CANCER, DIABETES,  
CVD AND STROKE**

## DIABETES, CVD AND STROKE COMPONENTS UNDER NPCDCS

- Urban Health check up scheme :  $\geq 30$  years and pregnant women
- 1) To screen urban slum population
- 2) To create database for prevalence
- 3) To sensitize the urban slum population about healthy lifestyle.
- National NCD cells at Centre, state and district levels to implement this program.

## CANCER COMPONENT UNDER NPCDCS

- National cancer control program launched in 1975-76
- Revised in 1984-85 and subsequently in December 2004
- 2010 got integrated with other components.
- Objectives: Primary, secondary and tertiary prevention
- Various schemes:
  - 1) Regional cancer Centre scheme
  - 2) Oncology Wing development scheme
  - 3) Decentralized NGO Scheme
  - 4) IEC activities at central level
  - 5) Research and training

**INTEGRATED DISEASE**  
**SURVEILLANCE PROJECT**

- Launched in Nov 2004 .
- 5 year project
- It is a decentralized based surveillance system in the country.
- Detect early warning signals
- Both urban and rural areas
- Different types of integrations are proposed:
  - 1) Sharing of surveillance information of disease control program
  - 2) Developing effective partnership with health and non-health sectors
  - 3) Effective partnership with private sectors and NGOs
  - 4) Bringing academic institutions into primary public health activity of disease surveillance.



# NATIONAL WATER SUPPLY AND SANITATION PROGRAMS

- Initiated in 1954
- 1972 Accelerated rural water supply program
- 5<sup>th</sup> Five year plan , the above included with the MINIMUM NEEDS PROGRAM of the State Plan
- Problem Village = Where no source of safe water available in a distance of 1.6km, or at the depth of 15m or has the source of extreme salinity, iron, fluorides and other toxic elements or where water is exposed to the risk of cholera.
- Program renamed as RAJIV GANDHI NATIONAL DRINKING WATER MISSION in 1991.
- 2002 – Swajaldhara
- 2009 – renamed as NATIONAL RURAL DRINKING WATER PROGRAM. (Part of BHARAT NIRMAN 2005)

**RURAL SANITATION PROGRAM:**

- NIRMAL BHARAT ABHYAN – 2012
- SWACH BHARAT ABHYAN – 2<sup>nd</sup> Oct 2014 launched by the Prime Minister Modi.

Vision of clean India by 2<sup>nd</sup> Oct 2019.

# MINIMUM NEEDS PROGRAM

- Introduced in 1<sup>st</sup> year of 5<sup>th</sup> Five year plan.
- 1974-78
- Objective was to provide certain basic needs to raise the standard of living
- Components:
  - 1) Rural Health
  - 2) Rural Water Supply
  - 3) Rural Electrification
  - 4) Elementary Education
  - 5) Adult Education
  - 6) Nutrition
  - 7) Environmental Improvement of Urban Slums
  - 8) Houses of landless laborers

## 20-POINT PROGRAM

- In addition to five year plan Govt of India initiated a special activity.
- Described as an agenda for national action to promote social justice and economic growth.
- 1986 – restructured the program.
- Objectives : Eradication of poverty, raising productivity, reducing inequality, removing social and economic disparity and improving the quality of life.
- 8 points related to health out of 20.

Point 1 : attack of rural poverty

Point 7 : Clean drinking water

Point 8 : Health for all

Point 9 : Two child norm

Point 10 : Expansion of education

Point 14 : Housing for the people

Point 15 : Improvement of slum

Point 17 : Protection of the environment.

# CONCLUSION



- There are various other National Health programs as well, like :

Rabies control program

Guinea worm eradication program

Leprosy eradication program

National program for control of blindness and deafness

National program for burn injuries and trauma

Emergency preparedness program

Universal Immunization program

YAWS control Program

National program for prevention and control of fluorosis etc.

- The major drawback of all the national program are gaps still present between the recipients and hosts especially in the rural areas.

- Well-planned investment, complemented by cooperation between the research and implementation communities on research, evaluation and training can fill these gaps and make an important contribution to improving health.

**THANK YOU**